MARCH 2020 HIGHLIGHTS

Congressional Testimony

Deputy Inspector General Testifies before the House Committee on Veterans' Affairs Subcommittee on Technology Modernization

Mr. David Case, Deputy Inspector General, testified at a hearing before the House Committee on Veterans' Affairs Technology Modernization Subcommittee March 5, 2020, on "Getting It Right: Challenges with the Go-Live of Electronic Health Record Modernization." Mr. Case's testimony was drawn from two not-yet-published VA Office of Inspector General (OIG) reports, *Review of Access to Care and Capabilities During the Transition to VA's New EHR* and *Deficiencies in Infrastructure Readiness for Deploying VA's New Electronic Health Record System*. He explained that the OIG's work found VA had not met its own readiness guidelines for deploying the new Electronic Health Record (EHR) to the Mann-Grandstaff VA Medical Center in Spokane, Washington, and that the mitigations for incomplete capabilities—for example, requiring staff to use at least two internal systems and sometimes third-party software to find and manually transfer information, verify patient eligibility, and track approvals, all while providing patient care—posed significant patient safety risks. During the hearing, Mr. Case explained that the VA OIG would continue oversight of the EHR modernization program and monitor VA's new schedule for going live and deploying the system's full capabilities incrementally.

Counselor to the Inspector General Testifies before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations

Mr. Christopher Wilber, Counselor to the Inspector General, testified at a hearing before the House Committee on Veterans' Affairs Oversight and Investigations Subcommittee March 10, 2020, on pending legislation including H.R. 5843, the Strengthening Oversight for Veterans Act of 2020. Mr. Wilber testified in support of the bill, which would give the VA OIG testimonial subpoena authority. He explained how it would strengthen the VA OIG's work, discussed examples of inspections and investigations where the VA OIG could not interview former VA employees, and noted safeguards for witnesses.

Cash Rewards Program Payment

Reward for Report of Compensation Benefits Fraud

The VA OIG presented a reward to a confidential complainant who contacted the VA OIG Hotline to allege that a veteran was fraudulently receiving monthly VA and Social Security Administration (SSA) disability benefits. This information led to an investigation by the VA OIG and SSA OIG, which resulted in felony convictions of the veteran and his wife for conspiring to defraud VA and SSA. Because of the complainant's disclosure, VA saved over $1.9 million in benefits the veteran would

have received based on this false information. The defendants were also ordered to pay $177,270 in restitution to VA.

Criminal Investigations Involving Health Care

Former Veterans Health Administration Office of Community Care Benefits Adviser Found Guilty in Connection with Fraud Scheme

A former Veterans Health Administration (VHA) Office of Community Care benefits adviser was found guilty by a federal jury in the District of Colorado of healthcare fraud, conspiracy, payment of illegal kickbacks and gratuities, money laundering, and conflict of interest. An investigation by the VA OIG, FBI, and IRS Criminal Investigation (IRS CI) resulted in charges that, from May 2017 through June 2018, the defendant referred over 40 spina bifida beneficiaries to unlicensed home health agencies owned by friends or relatives. The unlawful referrals led to payments totaling approximately $19 million from VA to these home health agencies.

Former Sacramento, California, VA Medical Center Chief of Podiatry Sentenced for Healthcare Fraud

The former chief of podiatry for the Sacramento, California, VA Medical Center was sentenced in the Eastern District of California to 78 months' imprisonment and 24 months' supervised release and ordered to pay $234,260 in restitution to VA. A former VA prosthetics vendor, who was previously sentenced to 60 months' imprisonment and 36 months' supervised release, was also ordered to pay $479,360 in restitution to VA. An investigation by the VA OIG, Homeland Security Investigations, and VA Police Service resulted in charges that, between March 2008 and February 2015, the former chief and the vendor engaged in a scheme to defraud VA by billing for custom prescription footwear containing carbon graphite plates but instead provided veterans with inferior footwear containing preinstalled components. In addition, the chief, vendor, and a former employee of the vendor who separately pleaded guilty in December 2016 agreed to make materially false statements to VA regarding where their shoes were manufactured while applying for a national VA contract worth over $11 million per year.

Former Operator of Minnesota VA Community Based Outpatient Clinics Agrees to Pay $1.85 Million to Resolve False Claims Act Allegations

The company that formerly operated two VA community based outpatient clinics in Minnesota and the US Attorney's Office for the District of Minnesota agreed to a civil settlement under which the company agreed to pay $1.85 million to settle False Claims Act allegations. A VA OIG investigation resolved allegations that between July 2013 and April 2014, the company violated contract requirements for scheduling patient appointments at the Hibbing, Minnesota, community based outpatient clinic and falsified the dates when veterans requested appointments to make wait times appear shorter.

Defendant Sentenced for Defrauding VA's Civilian Health and Medical Program

A defendant in a nationwide healthcare fraud scheme involving the use of durable medical equipment, telemedicine doctors, and telemarketers was sentenced in the District of New Jersey to imprisonment of time served (10 months) and deported. The defendant, who previously pleaded guilty to money laundering and conspiracy to commit money laundering, was also ordered to forfeit $1.78 million. An investigation by the VA OIG, the Department of Health and Human Services (HHS) OIG, the FBI, and the IRS CI resulted in charges that the defendant participated in a scheme which solicited durable medical equipment to patients and used telemedicine doctors to certify medical necessity. The telemedicine doctors did not have relationships with the patients, and the telemarketers sold the completed orders to the durable medical equipment companies. Many of the target companies identified in the scheme received payments from the VA's Civilian Health and Medical Program. The loss to the government exceeds $1 billion. Of this amount, VA's loss is approximately $330,000.

Defendant Charged in Connection with COVID-19 Fraud Scheme

A defendant was arrested after being charged in the District of New Jersey with conspiracy to violate the Anti-Kickback Statute and conspiracy to commit healthcare fraud. An investigation by the VA OIG, FBI, IRS CI, Defense Criminal Investigative Service, and HHS OIG resulted in charges alleging the defendant participated in a conspiracy to defraud federally funded and private health care benefit programs by submitting fraudulent testing claims for coronavirus disease 2019 (COVID-19) and genetic cancer screenings. The defendant allegedly agreed with others to be paid kickbacks for each COVID-19 test bundled with an expensive respiratory pathogen panel test, which does not identify or treat COVID-19.

Miami, Florida, VA Medical Center Employee and Two Vendors Plead Guilty in Connection with Bribery Scheme

A Miami, Florida, VA medical center employee pleaded guilty to bribery and two vendors pleaded guilty to conspiracy to commit healthcare fraud in the Southern District of Florida. A VA OIG investigation that was initiated based on a hotline complaint resulted in charges that the defendants and 13 others engaged in a bribery and kickback scheme involving multiple vendors and employees of the West Palm Beach and Miami VA medical centers. The charges allege that VA employees placed supply orders with the vendors in exchange for cash bribes and kickbacks. In many instances, the prices of supplies were grossly inflated; in other instances, the orders were only partially fulfilled or not fulfilled at all. From 2009 on, the vendors received millions of dollars from numerous VA medical centers throughout the country through purchase card orders and service and construction contracts.

Daughter of Ex-Employee at The Villages, Florida, VA Outpatient Clinic Pleads Guilty to False Statements

The daughter of a former transportation assistant at VA's outpatient clinic in The Villages, Florida, pleaded guilty in the Middle District of Florida to false statements. A VA OIG investigation resulted in charges that the former VA employee conspired with the defendant and another relative to create and

control two companies to which he steered VA transportation assignments. As a result, VA paid the companies $305,673. The former VA employee also allegedly solicited and received approximately $76,789 in kickbacks from two other transportation vendors.

Veteran Pleads Guilty in Connection with Shooting at West Palm Beach, Florida, VA Medical Center

A veteran pleaded guilty in the Southern District of Florida to possession of a firearm in a federal facility to commit a crime and assaulting federal employees. A VA OIG and FBI investigation revealed that on February 27, 2019, the defendant inflicted non-life-threatening injuries on three VA emergency room employees by firing a handgun inside the West Palm Beach, Florida, VA Medical Center.

Former Des Moines, Iowa, VA Medical Center Registered Nurse Pleads Guilty to Drug Diversion

A former VA nurse pleaded guilty in the Southern District of Iowa to acquiring controlled substances by misrepresentation, fraud, deception, and subterfuge. A VA OIG and VA Police Service investigation revealed the defendant diverted hydromorphone and other narcotics from the medical center for approximately seven months.

Former Fort Harrison, Montana, VA Medical Center Psychiatrist Pleads Guilty to Unlawful Possession of a Controlled Substance

A former VA psychiatrist pleaded guilty in the District of Montana to unlawful possession of a controlled substance. An investigation by the VA OIG, Drug Enforcement Administration, and VA Police Service revealed the defendant used a VA prescription pad to prescribe a controlled narcotic to his nonveteran girlfriend.

Criminal Investigations Involving Benefits

Former VA Fiduciary Sentenced in Connection with Fraud Scheme

A former VA-appointed professional fiduciary was sentenced in the District of New Mexico to 240 months' imprisonment and 36 months' supervised release and ordered to pay restitution of $11.18 million. An investigation by the VA OIG, SSA OIG, FBI, and IRS CI, which was initiated based on a hotline complaint, revealed the defendant and three codefendants engaged in a sophisticated financial scheme to use their nonprofit organization to defraud victims of their VA and SSA benefits. The defendants unlawfully transferred money from their clients' accounts to their own business accounts. The defendants then used funds from these comingled accounts to purchase homes, vehicles, luxury recreational vehicles, and cruises. Fifty-two veterans were harmed by this scheme. The loss to VA is approximately $3.3 million.

Veteran Sentenced for Compensation Benefits Fraud Scheme

A veteran was sentenced in the District of South Carolina to 21 months' imprisonment, 2 years' probation, and restitution of $175,448. The veteran and his wife previously pleaded guilty to conspiracy

to defraud VA for providing false statements to obtain additional VA compensation benefits and income from the VA Caregiver Support Program. The veteran's father previously pleaded guilty to misprision of a felony for providing misleading statements regarding his son's disabilities. A VA OIG investigation revealed the veteran owned various companies while receiving Individual Unemployability benefits and claiming to be unemployed due to his service-connected disabilities. The veteran obtained multiple government set-aside contracts, most with VA, totaling over $2 million while being rated permanently and totally disabled. An investigation revealed the veteran obtained a private pilot license and an aircraft mechanic certification days after reporting multiple disabilities to VA but not to the Federal Aviation Administration. The defendants' companies were debarred from government contracting.

Criminal Investigations Involving Other Matters

Veteran Indicted in Connection with Service-Disabled Veteran-Owned Small Business Fraud Scheme

The veteran owner of a service-disabled veteran-owned small business was indicted in the District of Kansas on charges of wire fraud and making a false statement. An investigation by the VA OIG, Department of Labor (DOL) OIG, and General Services Administration OIG resulted in charges alleging the defendant participated in a "pass-through" scheme in which she falsely claimed to control the business, when in fact other individuals held ownership interest and controlled the company. The defendant also allegedly submitted false information to several government agencies to qualify her business as a service-disabled veteran-owned small business. From March 2010 to February 2018, the defendant's company was awarded approximately $4.8 million in set-aside contracts, of which approximately $4.2 million were awarded by VA.

Defendant Found Guilty in Compounding Pharmacy Scheme

The former owner of a pharmacy was found guilty by a federal jury in the Southern District of Texas of charges including conspiracy to pay healthcare kickbacks, conspiracy to commit healthcare fraud, healthcare fraud, and wire fraud. An investigation by the VA OIG, US Postal Service OIG, Department of Homeland Security OIG, DOL OIG, and IRS CI resulted in charges that the defendant conspired with others to pay kickbacks to physicians to induce them to write prescriptions for compounded gels and creams dispensed by his pharmacy. The payments for these prescriptions were made by DOL's Office of Workers' Compensation Programs. Between 2011 and 2016, the codefendants billed the federal government over $21 million for compounded gels and creams, and received over $11 million in payments from DOL. The loss to VA is approximately $609,900.

Audits and Reviews

QTC Medical Services Complied with Medical Disability Examination Billing Requirements

The VA OIG conducted this review of QTC Medical Services (QTC), a company VA contracts with to conduct medical disability exams for veterans and active military members. Prior VA OIG and independent auditor reviews identified deficiencies with the company's billing practices that yielded significant questioned costs. The review team's objective was to determine whether the company maintained corrective measures to address the previously identified issues, and to follow up on recent billing practices. The review team sampled two months of billings totaling more than $12 million and found QTC was complying with the billing requirements in its current contracts and not engaging in overbilling or other previously identified concerning practices. The VA OIG therefore made no recommendations.

Risk Assessment of VA's Grant Closeout Process

The VA OIG performed a risk assessment of VA's grant closeout process to determine if an audit or review of the process was warranted, as required by the Grants Oversight and New Efficiency Act of 2016. The assessment team concluded that neither was warranted. VA reported 34 expired grants more than two years old with undisbursed balances as of the end of fiscal year (FY) 2019. The reported undisbursed balances were reduced to less than $500,000 when the team adjusted for discrepancies between a grants payment system and VA's financial management system. For FY 2020, the estimated budgets for the assessed grant programs totaled only about 1 percent of VA's overall budget estimate. Moreover, VA's largest grant program, State Home Per Diem, obligates funds when an invoice is paid. Accordingly, for about 67 percent of the $2.27 billion grant budget, VA has implemented a process to mitigate the risk of undisbursed balances.

Federal Information Security Modernization Act Audit for Fiscal Year 2019

The VA OIG contracted with an independent public accounting firm to assess VA's information security program for FY 2019, in accordance with the Federal Information Security Modernization Act (FISMA). The firm, CliftonLarsonAllen LLP, evaluated 49 major applications and general support systems hosted at 24 VA facilities. The firm concluded that VA continues to face significant challenges meeting FISMA requirements and made 25 recommendations. Recommendations included improving both performance monitoring and the deployment of security patches and system upgrades. The firm noted that all recommendations were repeated or modified from previous reports on FISMA compliance. CliftonLarsonAllen LLP will follow up on outstanding recommendations and evaluate VA's corrective actions during its FISMA audit for FY 2020. If delays in addressing recommendations continue, the VA OIG is concerned that a material weakness in informational technology security controls may be reported in the FY 2020 audit of VA's consolidated financial statements.

National Healthcare Review

VA OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness

The VA OIG evaluated COVID-19 screening processes at 237 VA facilities and collected data on pandemic preparations. Screening processes were adequate at 71 percent of visited medical centers, and many community based outpatient clinics had screening procedures in place. Although VA announced a no visitors policy for community living centers on March 10, 2020, VA OIG staff had access to nine. Almost all medical facilities visited were collecting COVID-19 specimens, but only the VA Palo Alto Health Care System had the capability to process them. Facility leaders reported that the medication inventory may be insufficient, and some expressed concerns with their inventory of COVID-19 testing kits and personal protective equipment. Almost half of facility leaders reported a rise in absenteeism but were able to provide coverage to minimize impact. As of March 19, 2020, 43 percent of facility leaders reported plans to share intensive care beds and personal protective equipment supplies with community providers. Most leaders said they would send patients to another VA medical center or a private, community, university, or Department of Defense hospital if unable to meet patient care needs related to COVID-19.

Healthcare Inspections

Alleged Deficiencies Related to the Cardiac Catheterization and Electrophysiology Laboratories at the Jesse Brown VA Medical Center, Chicago, Illinois

The VA OIG initiated an inspection regarding concerns within the cardiac catheterization and electrophysiology laboratories at the facility. The VA OIG substantiated that complications occurred in patients who underwent cardiac procedures. However, the complications were not due to deficiencies and were consistent with known risks. The VA OIG determined that leaders followed VHA policy in response to the death of one patient who underwent a cardiac catheterization procedure. The VA OIG did not substantiate that an anesthesiologist had concerns about the cardiac catheterization laboratory. The Cardiopulmonary Resuscitation Committee meeting minutes lacked a way to identify a specific code event; however, a previous OIG team recommended the committee review each resuscitative episode. The VA OIG substantiated that the acting chief of staff was aware of cardiac catheterization laboratory issues but did not substantiate that no follow-up action occurred. The VA OIG did not substantiate that a cardiologist was absent during procedures or that cardiology fellows performed procedures independently. The VA OIG made no recommendations.

Deficient Staffing and Competencies in Sterile Processing Services at the VA Black Hills Healthcare System, Fort Meade Campus, South Dakota

The VA OIG assessed an allegation that a facility leader endangered patient safety by placing an unqualified leader as the acting chief of sterile processing services (SPS) at the facility. The VA OIG did not substantiate that the detailed acting chief endangered patient safety. Facility leaders based incumbent selection on leadership experience and the individual's workload, which the detailed acting chief had. The VA OIG found no patients were harmed. Facility leaders failed to comply with a 2009 memorandum requiring complexity Level 1 and 2 facilities to have SPS assistant chief positions. Unreliable processes for identifying changes in manufacturer's instructions led to improper sterilization of some instruments; however, appropriate actions were taken, and an analysis determined that patient risk was minimal. A lack of stable SPS leadership was identified as a possible reason for failure to identify the change to the manufacturer's instructions and update staff competencies. The VA OIG made three recommendations.

Deficiencies in a Cardiac Research Study at the VA St. Louis Health Care System, Missouri

The VA OIG conducted a healthcare inspection to evaluate a research cardiologist's provision of follow-up care, a cardiology fellow's provision of follow-up care and interpretation of electrocardiograms, the oversight of facility research bodies, and stress-test procedure instructions. After a research cardiologist failed to initiate cardiac follow-up care or notify a patient and the patient's primary provider of positive stress-test results, the cardiology fellow managed follow-up care; however, the VA OIG was unable to determine if the fellow had difficulty interpreting electrocardiograms. The facility research oversight bodies did not ensure primary providers' notification of patient enrollments in a research study. Instructions provided to cardiology fellows differed from the protocol used by facility staff. The VA OIG made six recommendations related to stress-test results; a review of enrolled patients' result notifications and follow-up care; disclosure; research oversight; and review of the stress-test laboratory educational material.

Deficiencies in the Administration of Emergent Mental Health Services at Coatesville VA Medical Center, Pennsylvania

The VA OIG inspected a patient's emergent mental health services, medication management, and emergency procedures at the facility. The VA OIG found that VHA did not provide guidance on time frames for requesting an extension of emergent mental health services or on notification processes. The chief of staff failed to review treatment notes and submit the extension request to the chief medical officer. The VA OIG did not substantiate that providers discontinued medications without transition to another program. Grant and Per Diem Program staff were instructed to call different emergency services for patients with other than honorable discharge status. Staff failed to follow up with one of five patients identified by the Recovery and Engagement and Coordination for Health—Veterans Enhanced Treatment Program. The patient died by suicide approximately three months later. The VA OIG made

two recommendations to the under secretary for health and two recommendations to the facility director related to processing requests to extend emergent mental health services, Grant and Per Diem Program medical emergency procedures, and follow-up of patients identified by the Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment Program.

To listen to the podcast on the VA OIG's March 2020 activity highlights, go to www.va.gov/oig/podcasts.